KORT New Patient Information

Patient Name:_____ E-Mail Address:_____

Address:_____ City/State/Zip:_____

Date of Birth:____/____/_____ Age:_____ Sex:_____ Social Security Number:_____-_____-_____

Marital Status:_____ Phone: _____

Employer/School:_____

Occupation:_____

Employer Address:_____

Work Phone Number:_____

Spouse (or parent, if minor):_____

Phone Number: _____-_____-_____

Spouse or Parent Employer:_____

Address:_____

Contact Person Outside Home:_____

Phone No.:_____

Referring Physician:_____

Primary Care Physician:_____

Onset Date (injury, accident, surgery date or recent date symptoms started): :____/____/_____

(For workers compensation or auto accident we must have the date of injury.)

How did you hear about us?

Family/Friend ❒ TV/Radio ❒ Referral ❒ Internet ❒ Other ❒

CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize KORT Physical Therapy, through its appropriate personnel, to furnish medical care and treatment to me or the above name patient, considered necessary and proper in diagnosing or treating my/his/her physical condition.

Signature: _____ (relationship to patient: self – guardian – other _____) Date:_____

I further authorize KORT Physical Therapy to release to appropriate agencies any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided.

Signature: _____ (relationship to patient: self – guardian – other _____) Date:_____

STATEMENT OF FINANCIAL RESPONSIBILITY

Patient Name: _____ Date:_____ Acct:_____

KORT Physical Therapy appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payment at the time of service and for any deductible/coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your clam, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. For your convenience, we accept cash, checks, and most major credit cards. Payment is expected by payment due date on your Monthly Patient Statement. Payments can be made at the clinic, mailed to the address on your statement, or you may access our on-line bill payment system @ https://KORT.com once a statement is received from the billing office, or by calling our Customer Service Department at 1-855-716-6412.

I have read the above policy regarding my financial responsibility to KORT Physical Therapy for providing rehabilitative services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to KORT Physical Therapy. I agree to pay KORT Physical Therapy the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier.

PSS Initials: _____

Signature: _____ (relationship to patient: self – guardian – other _____) Date:_____

BILLING DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this form.

I authorize KORT to disclose my health information that is directly related to my current treatment at KORT to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Such persons involved in your care may include spouses, children, blood relatives, roommates, boyfriends or girlfriends, domestic partners, neighbors and colleagues.

Name: _____ Relationship:_____

Name: _____ Relationship:_____

I acknowledge that the Notice of Privacy Practice is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy and one will be provided to me.

Signature: _____ (relationship to patient: self – guardian – other _____) Date:_____

WHAT IS AIDS?

AIDS is the Acquired Immune Deficiency Syndrome – a serious illness that makes the body unable to fight infection. A person with AIDS is susceptible to certain infections and cancers. When a person with AIDS cannot fight off infections, this person becomes ill. These infections can eventually kill a person with AIDS.

☐ **Check box if you want more information on HIV and AIDS.**

KORT
The Best In Rehab.

Attention all Medicare Beneficiaries…

Beginning January 1, 201癸your Medicare benefit for Physical, Occupational, and Speech Therapy will have the following restrictions:

- **Physical and Speech Therapy combined $1,940**
- **Occupational Therapy $1,940**

This is an annual financial limitation per calendar year (January 1 through December 31, 2015) for any outpatient therapy services, including hospital-based outpatient facility therapy services.

Any therapy you have received for this condition or another condition may apply to this limitation. In order to assist you in knowing if you have met your limitation, please inform our staff of any therapy you received during the year, beginning January 1, 2015 by any therapy provider.

If you require skilled therapy services beyond this dollar amount, your therapist can discuss options with you.

In addition, Medicare has an annual Part B deductible of $147 for 2015. If you have either a Medicare supplement or a secondary insurance plan, it may or may not cover this deductible. We will bill all insurance plans you have identified and should your insurance not cover the deductible, we will bill you for any remaining balance once your claim has been considered for payment.

Please let your Patient Service Specialist or therapist know if you have any questions.

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Medicare Secondary Payor (MSP) Questionnaire – Page 1

IMPORTANT NOTICE TO PATIENT: Please fill out this form in its entirety. Failure to do so may result in a delay in obtaining your Medicare benefits.

Office Use Only

Patient Name: _____ **Clinic Name:** _____

Medicare Number: _____ **Patient Acct#:** _____

(exactly as appears – Red-White-Blue Government Medicare Card) **Database:**_____

1. **Have you received Home Health Care of any kind in the past 60 days or currently are residing in a Skilled Nursing Facility? ..... Yes No**
   Agency Name/Facility Name: _____
   Phone: _____
   If in a Skilled Nursing Facility: **Are you on/in the "Medicare Unit"?.....** Yes No

2. **Are you entitled to benefits under the Black Lung Program, Dept. of Veteran Affairs or other government program? ..... Yes No**
   If yes, Program Name:_____ Phone: _____
   Address, City, State, ZIP:

   NOTE: *The government program listed in question #2 will be primary to Medicare.*

3. **Was this injury/illness due to any of the following?**
   Work-related? **If yes**, date of accident/injury: _____ /_____ /_____..... **Yes No**
   Auto accident? **If yes**, date of accident: _____ /_____ /_____ ..... **Yes No**
   Accident on Property? (other than your own)(Example: store, restaurant, etc.) ..... **Yes No**
   If yes, date of accident: _____ /_____ /_____
   If yes, please give details of the accident:

   If yes, please provide the following information about the **liability insurance**: Insurance Name:_____ Phone: _____
   Address, City, State, ZIP:

   Contact Person/Adjustor's Name: _____ **Claim Number**: _____ (**required**)
   NOTE: *Medicare regulations require us to file with the above liability insurance first, even if they will not pay directly or immediately. We must comply with this regulation before filing with Medicare. Your understanding and cooperation is appreciated.*

4. **Do you feel you have a right to be compensated by a party who may have caused the injury or illness?** ..... **Yes No**
   If yes, do you intend to file a liability claim or lawsuit in connection with this injury or illness? ..... Yes No
   If yes, Attorney's Name: _____
   Law Firm Name: _____
   Address: _____
   Phone number: _____

(**Page 1 of 2 – Go to Page 2)**

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Medicare Secondary Payor (MSP) Questionnaire – Page 2

IMPORTANT NOTICE TO PATIENT: Please fill out this form in its entirety. Failure to do so may result in a delay in obtaining your Medicare benefits.

Patient Name: **Clinic Name:**
Medicare Number: **Patient Acct#:**
(exactly as displayed on Red-White-Blue Government Medicare Card) **Database:**

5. Have you received a kidney transplant or are currently receiving dialysis for End Stage Renal Disease (ESRD)? ..... Yes No

If yes, please provide the date of the transplant or start of dialysis: ____/____/____

If the date is less than 30 months ago:

Are you currently covered under group insurance provided by your or a family member's employer? ……Yes No

If yes – the group insurance will be primary **If no** – Medicare will be primary

6. Are you currently employed?..... **Yes No**

If yes, Does your employer employ more than 20 employees? .....Yes No

If no, Date of retirement:_____/_____/_____ or check ☐ Not employed

Is your spouse currently employed?..... **Yes No**

If yes, Does his/her employer employ more than 20 employees?..... Yes No

If no, Date of retirement:_____/_____/_____ or check ☐ Not employed

(NOTE: If both are not currently employed, then Medicare is primary.)

7. If you've answered No to questions 1 – 6 AND your Medicare coverage is due to age or disability: Do you have a group insurance plan through another family member's current employer? ..... Yes No

If yes – the group insurance will be primary **If no** – Medicare will be primary

Do you have any benefits through TriCare (formerly Champus)? ..... **Yes No**

8. If you answered YES to questions 6 or 7, please complete the following group insurance information for the proper billing of your account:

Insurance Co. Name:_____

Address:_____

City, State, ZIP:_____

Phone: _____

Employer Name: _____

Insured's Name:_____

Policy Identification #: _____

(Sometimes referred to as the health insurance benefit package number)

Group Identification #: _____

_____

Patient Signature Date

_____

Appointed Representative Signature Relationship

Medical Screening Form

KORT
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Name:_____Date:_____

Please circle YES or NO

Do You Have A History Of:	SELF	FAMILY
Diabetes?	Yes…No	Yes…No
High Blood Pressure?	Yes…No	Yes…No
Heart Attack?	Yes…No	Yes…No
Heart Disease?	Yes…No	Yes…No
High Blood Cholesterol?	Yes…No	Yes…No
Smoking?	Yes…No	Yes…No
Chest Pain?	Yes…No	Yes…No
Dizziness/Fainting?	Yes…No	
Shortness of Breath?	Yes…No	
Ankle Swelling?	Yes…No	
Night Coughing?	Yes…No	
Stroke?	Yes…No	Yes…No
Cancer?	Yes…No	Yes…No
Osteoporosis?	Yes…No	Yes…No
Osteoarthritis?	Yes…No	Yes…No
Rheumatoid Arthritis?	Yes…No	Yes…No
Rheumatic Disease?	Yes…No	Yes…No
Alcohol Use?	Yes…No	
↳Current number drinks/week?	_____	
Allergies?	Yes…No	
↳Type?	_____	
Asthma?	Yes…No	
↳Always have inhaler with you?	Yes…No	
Childhood Diseases?	Yes…No	
Falling?	Yes…No	
↳Number of times in last year?	_____	
Headaches?	Yes…No	
Kidney Disease?	Yes…No	
Lung Disease?	Yes…No	
STDs?	Yes…No	
Seizures?	Yes…No	
Pacemaker/Defibrillator?	Yes…No	
Assistive Device (e.g. cane)?	Yes…No	

In the Past 3 Months, Have You Experienced:	
Unexplained change in your health?	Yes…No
↳If yes, please describe:	
_____	
Explained illness or injury?	Yes…No
↳If yes, please describe:	
_____	
Unexplained weight change?	Yes…No
Night sweats?	Yes…No
Fever?	Yes…No
Numbness or tingling?	Yes…No
Changes or difficulty with bowel?	Yes…No
Changes or difficulty with bladder?	Yes…No

In the past month, have you frequently been bothered by feeling down, depressed or hopeless? …….. Yes … No

In the past month, have you frequently been bothered by having little interest in things or have you lost pleasure in doing things? …… Yes … No

Do you have a problem with … (check all that apply)

☐ Hearing ☐ Speech
☐ Vision ☐ Communication

Do you regularly exercise? …….. Yes … No
Number of days per week? _____
Number of minutes per session? _____

What is your body weight? _____ height? _____

Please list any medicine allergies you may have:
_____
_____

Are you allergic to Latex? Yes…No Adhesives? Yes…No

Please list or provide a copy of the medications you are currently taking: (Dosages not necessary)
_____
_____
_____

Please list any major surgeries in your past:
_____
_____
_____
_____

Other:
_____
_____
_____
_____
_____

Women:

Are you or could you be pregnant? …….. Yes … No

Patient/Representative Signature:_____ Therapist Signature: _____

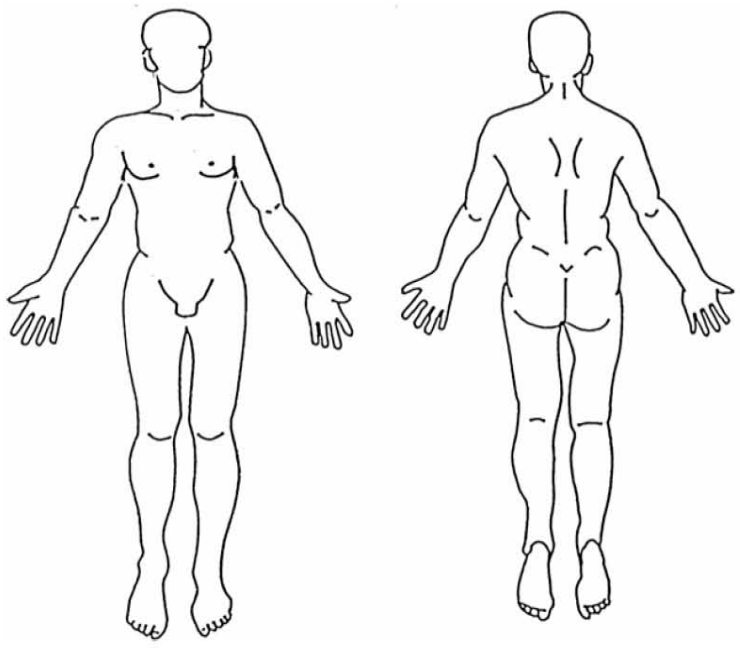
Medical Screening Form – Page 2

Name:_____Date:_____

Please use the diagram below to indicate where you feel symptoms right now.

Use the key below to indicate the different types of symptoms:

KEY: Pins & Needles = oooooooo Stabbing = //////////
Burning = XXXXXX Deep Ache = ZZZZZZZ



Please mark your ***best (B), current (C), and worst (W)*** level of pain or symptom on the following line:

_____

0 1 2 3 4 5 6 7 8 9 10

(**0** = none →**10** = worst imaginable. Indicate level for each with B, C, and W)

What makes your pain or symptom worse?

_____

What makes your pain or symptom better?

_____

Are your symptoms: (check one)
□ Getting worse □ The same □ Improving

How are you able to sleep at night? (check one)
□ Fine □ Moderate Difficulty □ Only with Medication

Do you have pain at night? Yes … No

When (date) did your problem begin? _____

Have you been treated for this before? Yes … No
When? How?_____

PATIENT SPECIFIC FUNCTIONAL SCALE

Please list three (3) activities that you are having difficulty performing. Please rate your ability next to each activity

(**0** = unable to perform → **10** = can perform normally)

1. _____ _____
   0 1 2 3 4 5 6 7 8 9 10
2. _____ _____
   0 1 2 3 4 5 6 7 8 9 10
3. _____ _____
   0 1 2 3 4 5 6 7 8 9 10

Other Relevant Information? _____
_____
_____
_____

Patient or Representative Signature: _____ Date: _____

Reviewer Signature/Initials: _____ Date: _____